Independence

Medical Benefit Highlights

Keystone Health Plan East HMO C3-F4 NSM Insurance Group

Covered Services	Your Costs (You pay)	
Benefits per Calendar Year	**Referred**	**Out-of-Network**
Deductible Individual/Family	$0/$0	Not covered
Out-of-Pocket Maximum (Embedded)[1] Individual/Family	$6,600/$13,200	Not covered
Coinsurance	0%	Not covered
Preventive Services	**Referred**	**Out-of-Network**
Preventive Care	No charge	Not covered
Preventive Colonoscopy		
Preventive Plus Providers	No charge	Not covered
Hospital Based	No charge	Not covered
Physician Services	**Referred**	**Out-of-Network**
Primary Care Physician (PCP) Office Visit	$20	Not covered
Specialist Office Visit	$40	Not covered
Retail Health Clinic Visit	$20	Not covered
Urgent Care Visit	$70	Not covered
Virtual Care[2]	**Referred**	**Out-of-Network**
Telemedicine	No charge	Not covered
Teledermatology	Not covered	Not covered
Telebehavioral Health	No charge	Not covered
Therapy Services	**Referred**	**Out-of-Network**
Physical Therapy (30 visits/year)[3]		
Freestanding	$40	Not covered
Hospital Based	$40	Not covered
Occupational Therapy (30 visits/year)[3]		
Freestanding	$40	Not covered
Hospital Based	$40	Not covered
Speech Therapy (20 visits/year)	$40	Not covered
Emergency Services	**Referred**	**Out-of-Network**
Emergency Room (copy not waived if admitted)	$100	Covered at In-Network level
Emergency Ambulance	No charge	Covered at In-Network level
Non-Emergency Ambulance	No charge	Not covered

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Hospital Services	Referred	Out-of-Network
Inpatient Hospital Services	$250/Day; max of 5 copays per admission	Not covered
Observation Services	No charge	Not covered
Maternity Hospital Services	$250/Day; max of 5 copays per admission	Not covered
Inpatient Professional Services (includes Maternity)	No charge	Not covered

Outpatient Surgery	Referred	Out-of-Network
Freestanding	$125	Not covered
Hospital Based	$125	Not covered
Outpatient Professional Services	No charge	Not covered

Outpatient Diagnostics	Referred	Out-of-Network
Diagnostic Medical (EKG)	$40	Not covered
Routine Radiology (X-Ray)		
Freestanding	$40	Not covered
Hospital Based	$40	Not covered
Advanced Imaging (MRI/MRA,CT/CTA Scan, PET Scan)		
Freestanding	$80	Not covered
Hospital Based	$80	Not covered

Outpatient Lab and Pathology	Referred	Out-of-Network
Freestanding	No charge	Not covered
Hospital Based	No charge	Not covered

Other Medical Services	Referred	Out-of-Network
Spinal Manipulations (20 visits/year)	$40	Not covered
Acupuncture (18 visits/year)	$40	Not covered
Standard Injectables	No charge	Not covered
Allergy Injections	No charge	Not covered
Biotech/Specialty Injectables		
Home/Office	$100	Not covered
Outpatient	$100	Not covered
Chemotherapy	No charge	Not covered
Dialysis	No charge	Not covered
Skilled Nursing Facility (120 days/year)	$125/Day; max of 5 copays per admission	Not covered
Home Health	No charge	Not covered
Hospice	No charge	Not covered
Durable Medical Equipment (DME)	50%	Not covered

Mental Health – Outpatient (includes serious mental illness and substance abuse)	$40	Not covered
Mental Health – Inpatient (includes serious mental illness and substance abuse)	$250/Day; max of 5 copays per admission	Not covered
Routine Eye Care	$40	Not covered

1 Embedded out-of-pocket maximum: Each covered family member only needs to satisfy his or her individual out-of-pocket maximum, not the entire family out-of-pocket maximum.

2 Telemedicine is provided by a designated telemedicine provider, please visit **www.ibx.com/findcarenow**.

3 Physical Therapy, Occupational Therapy, and Cognitive Therapy combined visit limit.

Keystone is a Health Maintenance Organization (HMO). This is a managed care program. Coverage is available when your care is provided or referred by a Keystone primary care physician (PCP). Your Keystone PCP may also refer you to other Keystone providers for care, if needed. Designated Site – PCPs are required to choose one radiology, physical therapy, occupational therapy, and laboratory provider where they will send their Keystone members. You can view the sites selected by your PCP at **www.ibx.com**.

This summary represents only a partial listing of benefits and exclusions of the Medical Program described in this summary. If your employer purchases another program, the benefits and exclusions may differ. Also, benefits and exclusions may be further defined by medical policy. As a result, this managed care plan may not cover all of your health care expenses. Read your contract/member benefit booklet carefully for a complete listing of terms, limitations, and exclusions of the program. For more information about your coverage, or to get a copy of the complete terms of coverage, visit **www.ibx.com/LGBooklet** or call **1-800-ASK-BLUE** (TTY: 711).

Benefits may be changed by Independence Blue Cross to comply with applicable federal/state laws and regulations.

Certain services require preapproval/precertification by the health plan prior to being performed. To obtain a list of services that require authorization, please log on to **http://www.ibx.com/preapproval** or call the phone number that is listed on the back of your identification card.

Benefits underwritten or administered by Keystone Health Plan East, a subsidiary of Independence Blue Cross - Independent licensees of the Blue Cross and Blue Shield Association. **www.ibx.com**

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Drug Benefit Highlights

Select Drug Program $20/$40/$60..

Covered Services	Your Costs (You pay)	
Benefits per Calendar Year	**In-Network**	**Out-of-Network**
Deductible Individual/Family	$0/$0	$0/$0
Out-of-Pocket Maximum Individual/Family	Combined with Medical	Combined with Medical
Formulary	Select	
Retail Pharmacy	**In-Network**	**Out-of-Network**
Tier 1 Generic Drugs	$20	30% Reimbursement
Tier 2 Preferred Brand	$40	30% Reimbursement
Tier 3 Non-Preferred Drugs	$60	30% Reimbursement
Dispensing Limits[1]	30 day supply max	30 day supply max
Mail Order Pharmacy **Available for maintenance drugs**	**In-Network**	**Out-of-Network**
Tier 1 Generic Drugs	$40	Not covered
Tier 2 Preferred Brand Drugs	$80	Not covered
Tier 3 Non-Preferred Drugs	$120	Not covered
Dispensing Limits[2]	90 day supply max	Not covered
Drug Coverage	**In-Network**	**Out-of-Network**
ACA Preventive Drugs	Covered	Covered
Compound Medications	Covered	Covered
Contraceptives	Covered	Covered
Diabetic Supplies (i.e., test strips)	Covered	Covered
Glucometers (no copayment/coinsurance required at participating pharmacies)	Covered	Covered
Insulin	Covered	Covered
Insulin Needles and Syringes	Covered	Covered
Lancets (no copayment/coinsurance required at participating pharmacies)	Covered	Covered
Prescribed Tobacco Cessation Drugs (RX and OTC)	Covered	Covered
Retin-A (up to Age 35)	Covered	Covered
Allergy Serum	Not covered	Not covered
Biologicals, Investigational/Experimental Drugs	Not covered	Not covered
Blood, Blood Plasma	Not covered	Not covered
Drugs used for Cosmetic Purposes	Not covered	Not covered
Immunization Agents	Not covered	Not covered
Injectable Fertility Drugs	Not covered	Not covered

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Non-Federal Legend Drugs	Not covered	Not covered
Over-The-Counter Drugs (Non-Prescription)	Not covered	Not covered
Weight Control Drugs	Not covered	Not covered

1 Maintenance medications may also be available for up to a 90-day supply at participating Act 207 Retail pharmacies for the same mail order member cost sharing as indicated above.

2 Mail order cost-sharing for 1-30 day supplies is equal to the in-network retail cost-sharing.

This summary represents only a partial listing of benefits and exclusions of the Prescription Drug Program described in this summary. If your employer purchases another program, the benefits and exclusions may differ. Also, benefits and exclusions may be further defined by pharmacy policy. As a result, this program may not cover all of your health care expenses. Read your contract/member benefit booklet carefully for a complete listing of terms, limitations, and exclusions of the program. For more information about your coverage, or to get a copy of the complete terms of coverage, visit **www.ibx.com/LGBooklet** or call **1-800-ASK-BLUE** (TTY: 711).

Certain designated preventative medications will not be subject to any cost-sharing or deductibles, but will be subject to the terms and conditions of your benefits contract. Refer to your summary of benefits, member handbook, and/or benefit booklet to determine if your plan includes 100 percent coverage for in-network preventive services.

Any prescription refilled in excess of the number of refills specified by the physician, or any refill dispensed after one year from the physician's original order are not covered. Devices or supplies except those specifically listed under covered drugs are not covered. Drugs used to treat hemophilia are not covered.

All covered self-administered specialty medications except insulin will be provided through the convenient Specialty Pharmacy Program for the appropriate cost sharing indicated above. Benefits are available for up to a thirty (30) days supply.

FutureScripts® network includes more than 65,000 retail pharmacies. You can locate a participating pharmacy near you on **www.ibx.com** by selecting the Find a Participating Pharmacy feature.
FutureScripts® is an independent company providing pharmacy benefit management service.

Benefits underwritten or administered by Keystone Health Plan East, a subsidiary of Independence Blue Cross - Independent licensees of the Blue Cross and Blue Shield Association. **www.ibx.com**

Independence

Vision Benefit Highlights

$35 Eyewear Benefit

Covered Services	Your Costs (You pay)	
Benefits	**In-Network[1]**	**Out-of-Network**
Annual Plan Maximum	Unlimited	Unlimited
Deductible (Individual/Family)	$0/$0	$0/$0
Out-of-Pocket Maximum (Individual/Family)	$0/$0	$0/$0
Exam	**In-Network[1]**	**Out-of-Network**
Benefit Frequency	Not covered	Not covered
Routine Eye Exam at Davis Participating Providers	Not covered	Not covered
Lenses	**In-Network[1]**	**Out-of-Network[2]**
Benefit Frequency	1 / Every 24 Months	1 / Every 24 Months
Single Vision Lenses	No charge	$35 Reimbursement[3]
Bifocal Lenses	No charge	$35 Reimbursement[3]
Trifocal Lenses	No charge	$35 Reimbursement[3]
Lenticular Lenses	No charge	$35 Reimbursement[3]
Lens Options[4]		
Standard Progressive Lenses	$50	$35 Reimbursement[3]
Premium Progressive Lenses	$90	$35 Reimbursement[3]
Ultra Progressive Lenses	$140	$35 Reimbursement[3]
Ultimate Progressive Lenses	$175	$35 Reimbursement[3]
Polycarbonate Lenses – Single Vision[5]	$30	Not applicable
Polycarbonate Lenses – Multifocal Vision[5]	$30	Not applicable
Photosensitive Lenses – Single Vision	$60	Not applicable
Photosensitive Lenses – Multifocal Vision	$70	Not applicable
High-Index Lenses	$55	Not applicable
High-Index 1.74 Lenses	$120	Not applicable
Blue Light Lenses	$15	Not applicable
Polarized Lenses	$60	Not applicable
Lens Coatings		
Tinted Plastic Lenses	$11	Not applicable
UV-Coated Lenses	$12	Not applicable
Scratch-Resistant Coating Single-Vision Lenses	$15	Not applicable
Scratch-Resistant Coating Multifocal Lenses	$25	Not applicable
Scratch-Protection Plan Single Vision Lenses	Not covered	Not applicable
Scratch-Protection Plan Multifocal Vision Lenses	Not covered	Not applicable
Anti-Reflective Standard Lenses	$33	Not applicable
Anti-Reflective Premium Lenses	$48	Not applicable
Anti-Reflective Ultra Lenses	$60	Not applicable

Reference ID: A01012020

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Anti-Reflective Ultimate Lenses	$85	Not applicable

Frames	In-Network[1]	Out-of-Network
Benefit Frequency	1 / Every 24 Months	1 / Every 24 Months
Davis Collection Fashion Frames	No charge	Not applicable
Davis Collection Designer Frames	$16	Not applicable
Davis Collection Premier Frames	$35	Not applicable
Non-Davis Collection Frames	Up to $10 Allowance (plus a 20% discount on any overage)[6]	$35 Reimbursement[3]
Visionworks Frames Option	Up to $10 Allowance (plus a 20% discount on any overage) at Visionworks locations nationwide[6]	Not applicable

Contact Lenses (in lieu of glasses)	In-Network[1]	Out-of-Network
Benefit Frequency	1 / Every 24 Months	1 / Every 24 Months
Davis Collection Standard Daily Contact Lenses & Evaluation	Not covered	Not applicable
Davis Collection Specialty Contact Lenses & Evaluation	Not covered	Not applicable
Davis Collection Disposable Contact Lenses & Evaluation	Not covered	Not applicable
Non-Davis Collection Contact Lenses & Evaluation	Contacts: Up to $35 Allowance; Evaluation: Not covered; (plus a 15% discount on any overage)[6]	$35 Reimbursement
Medically-Necessary Contact Lenses[7]	No charge	Not covered

1 Participating Davis provider benefit.

2 Lens Options are subject to out-of-network base lens reimbursement. See your benefit booklet for reimbursement amounts.

3 Combined cost share.

4 Spectacle lens options are available at most participating providers and member pays fixed discounted prices.

5 Polycarbonate lenses for dependent children, monocular patients, and patients with prescriptions greater than or equal to +/6.00 diopters are covered at no cost.

6 Member is responsible for balance. Additional discounts not applicable at Walmart, Costco, or Sam's Club locations.

7 Covered with prior approval.

This summary represents only a partial listing of benefits of the Vision Care Program described in this summary. If your employer purchases another program, the benefits may differ. Also, benefits may be further defined by the vision policy. As a result, this vision plan may not cover all of your vision or health care expenses. Read your contract/member benefit booklet carefully for a complete listing of terms and limitations of the program. For more information about your coverage, or to get a copy of the complete terms of coverage, visit **www.ibx.com/LGBooklet** or call **1-800-ASK-BLUE** (TTY: 711).

Benefits may be changed by Independence Blue Cross to comply with applicable federal/state laws and regulations.

Administered by Davis Vision.

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Benefits underwritten or administered by Keystone Health Plan East, a subsidiary of Independence Blue Cross - Independent licensees of the Blue Cross and Blue Shield Association. **www.ibx.com**

Reference ID: A01012020

Independence

Dental Benefit Highlights

Basic Dental Program

Routine Covered Services

Keystone Health Plan East's Dental Program stresses prevention of dental disorders by encouraging you to have regular checkups. After a $5 copayment per visit, Keystone Health Plan East's Basic Dental Program provides 100% coverage for:

- Bitewing X-Rays
- Fillings
- Oral Examinations
- Cleanings
- Fluoride Treatments

With Keystone Health Plan East's Dental Program, there are no deductibles and no annual maximums.

Discounts Available for other Dental Care

Additional dental care is offered at discounted amounts when visiting a participating provider, such as:

- Bridges
- Dentures
- Oral Surgery
- Root Canals
- Crowns
- Endodontics
- Orthodontic Services
- Treatment of Gum Disease

How the Program Works

- You must select a participating primary dental office for you and your family from the Primary Dental Office Network listed in the Dental Directory. All family members must receive treatment from the same primary dental office. Once coverage is effective, you may call the primary dental office you have selected for an appointment.
- Additional specialty services may be offered at a discount when visiting a participating provider.

How to Receive Your Dental Benefits

Be sure to indicate the name and number of the primary dental office you have selected from the network in section three of the Keystone Health Plan East Enrollment Form. Return the completed Keystone Health Plan East Enrollment Form to your benefits office.

This summary represents only a partial listing of benefits of the Basic Dental Program described in this summary. If your employer purchases another program, the benefits may differ. Also, benefits may be further defined by the dental policy. As a result, this dental plan may not cover all of your dental or health care expenses. Read your contract/member benefit booklet carefully for a complete listing of terms limitations of the program. If you need more information, please call **1-800-ASK-BLUE** (TTY: 711).

This is intended only to be a summary to the services provided under the Basic Dental Program. For a complete listing of benefits refer to the Group Master Contract provided to your employer. As with Keystone Health Plan East's Medical Certificate of Coverage, there are specific exclusions and limitations under this Dental Program, including but not limited to: Services of dentists who are neither participating general dentists nor participating specialists; Services obtained from a specialist without written authorization from a participating primary dentist; Dental services or supplies that are cosmetic in nature, including personalized or specialized techniques; Dental services performed or initiated prior to the effective date of coverage or completed after the termination date of coverage; Dental services or supplies which are unnecessary or experimental according to accepted standards of dental practice; Surgical implants; Periodontal splinting; Services related to the treatment of temporomandibular joint dysfunction; General anesthesia; Any dental service for which the member is eligible under worker's compensation, under federal, state or local government programs, or dental services for which, in the absence of any health services or insurance program, no charge would be made to the individual; Services, the costs of which has been or is later recovered in any action at law or in compromise or settlement of any claim; Dental services performed in a hospital; Charges for broken appointments; Charges for additional treatment necessitated by lack of patient cooperation or failure to follow a professionally prescribed treatment plan; Treatment required as a result of an accidental injury, except for emergency treatment to relieve pain, and Services other than those specifically listed on the schedule.

Reference ID: BN01012019

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Language Assistance Services

Spanish: ATENCIÓN: Si habla español, cuenta con servicios de asistencia en idiomas disponibles de forma gratuita para usted. Llame al 1-800-275-2583 (TTY: 711).

Chinese: 注意：如果您讲中文，您可以得到免费的语言协助服务。致电 1-800-275-2583。

Korean: 안내사항: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-275-2583 번으로 전화하십시오.

Portuguese: ATENÇÃO: se você fala português, encontram-se disponíveis serviços gratuitos de assistência ao idioma. Ligue para 1-800-275-2583.

Gujarati: સૂચના: જો તમે ગુજરાતી બોલતા હો, તો નિ:શુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. 1-800-275-2583 કૉલ કરો.

Vietnamese: LƯU Ý: Nếu bạn nói tiếng Việt, chúng tôi sẽ cung cấp dịch vụ hỗ trợ ngôn ngữ miễn phí cho bạn. Hãy gọi 1-800-275-2583.

Russian: ВНИМАНИЕ: Если вы говорите по-русски, то можете бесплатно воспользоваться услугами перевода. Тел.: 1-800-275-2583.

Polish UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-800-275-2583.

Italian: ATTENZIONE: Se lei parla italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-800-275-2583.

Arabic:
ملحوظة: إذا كنت تتحدث اللغة العربية، فإن خدمات المساعدة اللغوية متاحة لك بالمجان. اتصل برقم 1-800-275-2583.

French Creole: ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-800-275-2583.

Tagalog: PAUNAWA: Kung nagsasalita ka ng Tagalog, magagamit mo ang mga serbisyo na tulong sa wika nang walang bayad. Tumawag sa 1-800-275-2583.

French: ATTENTION: Si vous parlez français, des services d'aide linguistique-vous sont proposés gratuitement. Appelez le 1-800-275-2583.

Pennsylvania Dutch: BASS UFF: Wann du Pennsylvania Deitsch schwetzscht, kannscht du Hilf griege in dei eegni Schprooch unni as es dich ennich eppes koschte zellt. Ruf die Nummer 1-800-275-2583.

Hindi: ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। कॉल करें 1-800-275-2583।

German: ACHTUNG: Wenn Sie Deutsch sprechen, können Sie kostenlos sprachliche Unterstützung anfordern. Wählen Sie 1-800-275-2583.

Japanese: 備考：母国語が日本語の方は、言語アシスタンスサービス（無料）をご利用いただけます。1-800-275-2583へお電話ください。

Persian (Farsi):
توجه: اگر فارسی صحبت می کنید، خدمات ترجمه به صورت رایگان برای شما فراهم می باشد. با شماره 1-800-275-2583 تماس بگیرید.

Navajo: Díí baa akó nínízin: Díí saad bee yáníłti'go Diné Bizaad, saad bee áká'ánída'áwo'dęę', t'áá jiik'eh. Hódíílnih kojį' 1-800-275-2583.

Urdu:
توجہ درکارہے: اگر آپ اردو زبان بولتے ہیں، تو آپ کے لئے مفت میں زبان معاون خدمات دستیاب ہیں۔ کال کریں 1-800-275-2583.

Mon-Khmer, Cambodian: សូមមេត្តាចាប់អារម្មណ៍៖ ប្រសិនបើអ្នកនិយាយភាសាមន-ខ្មែរ ឬភាសាខ្មែរ នោះជំនួយផ្នែកភាសានឹងមានផ្តល់ជូនដល់លោកអ្នកដោយឥតគិតថ្លៃ។ ទូរសព្ទទៅលេខ 1-800-275-2583។

Discrimination is Against the Law

This Plan complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. This Plan does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

This Plan provides:

- Free aids and services to people with disabilities to communicate effectively with us, such as: qualified sign language interpreters, and written information in other formats (large print, audio, accessible electronic formats, other formats).
- Free language services to people whose primary language is not English, such as: qualified interpreters and information written in other languages.

If you need these services, contact our Civil Rights Coordinator. If you believe that This Plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with our Civil Rights Coordinator. You can file a grievance in the following ways: In person or by mail: ATTN: Civil Rights Coordinator, 1901 Market Street, Philadelphia, PA 19103, By phone: 1-888-377-3933 (TTY: 711) By fax: 215-761-0245, By email: civilrightscoordinator@1901market.com. If you need help filing a grievance, our Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at *https://ocrportal.hhs.gov/ocr/portal/lobby.jsf* or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, 1-800-368-1019, 800-537-7697 (TDD). Complaint forms are available at *http://www.hhs.gov/ocr/office/file/index.html*.